

FEB 18 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **1468**
Registrar's No. **428**

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **General Hospital #2**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1-11-41-1-23-41**
(Specify whether years, months or days) **2 Months**

3. (a) PRINT FULL NAME

Richard Lee Miller Edwards

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex **Male**

5. Color or race **Negro**

6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased **11 11 1940**
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

2

12

hr.

min.

9. Birthplace **Kansas City**
(City, town, or county)

Mo.
(State or foreign country)

10. Usual occupation **none**

11. Industry or business

MOTHER FATHER

12. Name **Charles Edwards**

13. Birthplace **Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Georgia Miller**

15. Birthplace **Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Record Clerk**

(b) Address **General Hospital #2**

17. (a) **Burial** (b) Date thereof **1 29 41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Lincoln R.C. Ma.**

18. (a) Signature of funeral director **Adkins Bros.**

(b) Address **2000 E. 12th**

19. (a) **Jan 29 1941**
(Date received local registrar)

(b) **M. M. Brown**
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **1114 Belvedere**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **1** day **23**
year **41** hour **12** minute **A.** M.

21. I hereby certify that I attended the deceased from **1-11-** 19**41**, to **1-23-** 19**41**, that I last saw him alive on **1-23-** 19**41**, and that death occurred on the date and hour stated above.

Immediate cause of death

Lobar Pneumonia

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy **Above Mentioned**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature **P. P. Quares** (M.D. or other)
Address **Gen. Hosp #2** Date signed **1-27-41**

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.